2026 ANNUAL CONFERENCE & EXPO
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Then. Now. Next.

PDGM Structure

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PDGM – Key Elements of Successful Medicare Reimbursement

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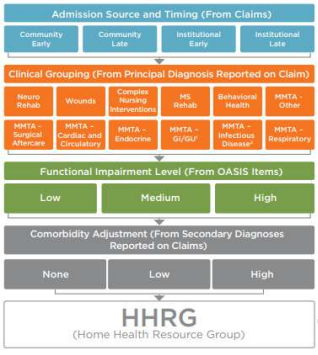
Patient-Driven Groupings Model (PDGM)



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Patient Driven Groupings Model (PDGM)

Admission Source & Timing (Claims) - (Community Early, Community Late, Institutional Early or Institutional Late)

- Only the first 30-day period in a SOC will be considered Early and all others late. the payment period could only be considered Early if greater than 60 days has passed since the end of a previous period of care.
- All subsequent 30-day periods (second or later) in a sequence of 30-day periods are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

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Patient Driven Groupings Model (PDGM)

Admission Source & Timing (Claims) - (Community Early, Community Late, Institutional Early or Institutional Late)

- Admission Source is Community or Institutional – depending on the healthcare setting utilized in the 14 days prior to home health (inpatient acute care hospitalization, skilled nursing facilities, inpatient rehabilitation facility, psychiatric or long-term care hospital)
- IMPORTANT: A post-acute stay (SNF, Rehab, LTCH, or Psych) in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay

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PDGM – Clinical Groupings

* MMTA – Surgical Aftercare
* MMTA – Cardiac/Circulatory
* MMTA – Endocrine
* MMTA – GI/GU
* MMTA – Infectious Diseases/Neoplasms
* MMTA – Respiratory
* MMTA – Other

Neuro Rehab
Wounds
Complex Nursing Interventions
Musculoskeletal (MS) Rehab
Behavioral Health

*Medication Management, Teaching and Assessment (MMTA)

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Percentage of Claims by Clinical Grouping

TABLE 6: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY THE 12 PDGM CLINICAL GROUPS, CYs 2018-2024

Clinical Grouping	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Behavioral Health	1.7%	1.5%	2.3%	2.4%	2.3%	2.2%	2.1%
Complex	2.6%	2.5%	3.5%	3.3%	3.2%	3.1%	3.1%
MMTA – Cardiac	16.5%	16.1%	18.9%	18.5%	17.9%	17.5%	17.1%
MMTA – Endocrine	17.3%	17.4%	7.2%	6.9%	6.8%	7.0%	7.1%
MMTA – GI/GU	2.2%	2.3%	4.7%	4.7%	4.9%	5.0%	5.2%
MMTA – Infectious	2.9%	2.7%	4.8%	4.6%	4.6%	4.7%	4.8%
MMTA – Other	4.7%	4.7%	3.1%	3.6%	3.5%	3.7%	3.8%
MMTA – Respiratory	4.3%	4.1%	7.8%	8.0%	7.8%	7.2%	7.0%
MMTA – Surgical Aftercare	1.8%	1.8%	3.6%	3.4%	3.4%	3.5%	3.5%
MS Rehab	17.1%	17.3%	19.4%	19.8%	20.8%	21.2%	21.4%
Neuro	14.4%	14.5%	10.5%	10.9%	11.0%	10.9%	10.8%
Wound	14.5%	15.1%	14.2%	13.9%	13.7%	14.0%	14.0%

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Coding

- Who is doing your coding?
- Are you ensuring that your coding staff have access to all medical records?
- Does coding staff have a valid Face-to-Face Encounter to assist with coding in a Start of Care?
- Does your coding staff have access to request additional information from physicians, if needed?
- Do you update the diagnosis codes when there is a change in condition?

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Change In Condition in 1st 30-day Period

- IMPORTANT - - However, if a patient experiences a significant change in condition before the start of a subsequent, contiguous 30-day period, for example due to a fall; a follow-up assessment would be submitted at the start of a second 30-day period to reflect any changes in the patient's condition, including functional abilities, and the second 30-day claim would be grouped into its appropriate case-mix group accordingly

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Comorbidity Adjustment

- **Low comorbidity adjustment**: (22 subgroups proposed) There is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups associated with higher resource use, or;
  - 6.22% increase in case-mix from No to Low
- **High comorbidity adjustment**: (90 subgroups proposed) There are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction that are associated with higher resource use.
  - 14.93% increase in case-mix from Low to High
- **Overall increase for a High Comorbidity adjustment = 21.15%**

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TABLE 22: LOW COMORBIDITY ADJUSTMENT SUBGROUPS FOR CY 2026

Low Comorbidity Subgroup	Description
Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae
Circulatory 10	Varicose Veins and Lymphedema
Circulatory 9	Other Venous Embolism and Thrombosis
Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease
Gastrointestinal 2	Intestinal Obstruction and Ileus
Heart 10	Dysrhythmias, includes Atrial Fibrillation and Atrial Flutter
Heart 11	Heart Failure
Heart 5	Atherosclerotic Heart Disease with Angina
Musculoskeletal 1	Lupus
Neoplasms 1	Malignant Neoplasms of Lip, Oral Cavity and Pharynx, includes Head and Neck Cancers
Neoplasms 17	Secondary neoplasms of respiratory and GI systems.
Neoplasms 18	Secondary Neoplasms of Urinary and Reproductive Systems, Skin, Brain, and Bone
Neoplasms 2	Malignant Neoplasms of Digestive Organs, includes Gastrointestinal Cancers
Neoplasms 6	Malignant neoplasms of trachea, bronchus, lung, and mediastinum
Neurological 10	Diabetes with neuropathy
Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
Skin 4	Stages Two-Four and unstageable pressure ulcers by site

Source: CY 2024 Home Health Claims Data, Periods that end in CY 2024 accessed on the CCW March 13, 2025.

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Patient Driven Groupings Model (PDGM)

Functional Level (OASIS Items) – (Low, Medium, High)

- Anticipates roughly 33% of periods of care will fall into each of the categories.
- M1800-M1860 (NOT M1845) and M1033 are OASIS-E Items will continue to determine the Functional Level
- GG items are not the same as the 1800 items - it is expected that they will eventually replace the M1800 items on the OASIS and in the PDGM calculations.
- GG items are currently used in RISK adjustment for outcomes calculations

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PDGM Functional Impairment – National

TABLE 9: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY FUNCTIONAL IMPAIRMENT LEVEL. CYs 2018-2024

Functional Impairment Level	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Low	33.9%	31.9%	25.7%	23.3%	28.1%	29.8%	30.3%
Medium	34.9%	35.5%	32.7%	32.6%	33.1%	31.8%	31.8%
High	31.2%	32.6%	41.7%	44.2%	38.8%	38.4%	37.8%

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OASIS Points Table – FINAL Rule 2026		Response	2025 Points	2026 FINAL	% of Periods
M1800: Grooming		2,3	3	3	76.8%
M1810: Current Ability to Dress Upper Body		2,3	5	5	82.4%
M1820: Current Ability to Dress Lower Body		2	3	4	64.2%
		3	11	12	27.3%
M1830: Bathing		2	3	2	9.3%
		3,4	10	10	48.7%
		5,6	18	17	39.8%
M1840: Toilet Transferring		2,3,4	5	6	40.6%
M1850: Transferring		1	1	1	17.2%
		2,3,4,5	4	4	81.8%
M1860: Ambulation		2	6	5	13.0%
		3	2	1	66.3%
		4,5,6	18	20	17.8%
M1033: Risk of Hospitalization	4 or more marked	1-7	12	12	43.6%

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Position #1		Position #2		Position #3		Position #4		Posit
Source & Timing		Clinical Group		Functional Level		Co-Morbidity		Plac
Community Early	1	MMTA_OTHER	A	Low	A	None	1	
Institutional Early	2	Neuro Rehab	B	Medium	B	Low	2	
Community Late	3	Wounds	C	High	C	High	3	
Institutional Late	4	Complex Nursing	D					
		MS Rehab	E					
		Behavioral Health	F					
		MMTA - Surgical Aftercare	G					
		MMTA - Cardiac	H					
		MMTA - Endocrine	I					
		MMTA - GI/GU	J					
		MMTA - Infectious	K					
		MMTA - Respiratory	L					

HIPPS Code

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Finalized Wage Index Changes

Finalized a permanent 5% cap on any decrease to a wage index from its wage index in the prior year, regardless of the circumstances causing the decline.

Finalized that a wage index for CY 2023 would not be less than 95 percent of its final wage index for CY 2022, regardless of whether the geographic area is part of an updated CBSA

Subsequent years, a wage index would not be less than 95% of its wage index calculated in the prior CY – also finalized, that if a prior CY wage index is calculated based on the 5% cap, then the following year's wage index would not be less than 95% of capped wage index

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Case-Mix Weight Adjustments

- Recalibrate annually the PDGM case-mix weights using a fixed effects model with the most recent and complete utilization data available at the time of annual rulemaking.
- Used CY 2023 home health claims data with linked OASIS data
- Reflective of PDGM utilization and patient resource use expected for CY2025
- Budget neutrality adjustment of 1.0039% applied to base rate

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Standard Base Rate – FINAL 2026

CY 2025 National Standardized 30-Day Period Payment	Permanent Adjustment Factor	CY 2026 Case-Mix Weights Recalibration Neutrality Factor	CY 2026 Wage Index Budget Neutrality Factor	CY 2026 HH Payment Update Factor	CY 2026 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2026 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,057.35	0.98977	1.0052	1.0025	1.024	$2,101.26	0.97000	$2,038.22

TABLE 26: CY 2026 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2025 National Standardized 30-Day Period Payment	Permanent Adjustment Factor	CY 2026 Case-Mix Weights Recalibration Neutrality Factor	CY 2026 Wage Index Budget Neutrality Factor	CY 2026 HH Payment Update Factor	CY 2026 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2026 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,057.35	0.95941	1.0051	1.0019	1.024	$2,035.38	0.95000	$1,933.61

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LUPA Rates

TABLE 28: CY 2026 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2025 Per-Visit Payment Amount	CY 2026 Wage Index Budget Neutrality Factor	CY 2026 HH Payment Update Factor	CY 2026 Per-Visit Payment Amount
Home Health Aide	$78.20	1.0004	1.024	$80.11
Medical Social Services	$276.85	1.0004	1.024	$283.61
Occupational Therapy	$190.08	1.0004	1.024	$194.72
Physical Therapy	$188.79	1.0004	1.024	$193.40
Skilled Nursing	$172.73	1.0004	1.024	$176.95
Speech-Language Pathology	$205.22	1.0004	1.024	$210.23

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LUPA Add-on Update 2026

LUPA Add-On %

- SN 1.7200
- PT 1.6225
- SLP 1.6696
- OT 1.7238

To calculate the payment, multiply the per-visit payment amount for the Start of Care visits - SN, PT, SLP or OT visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount.

For example, using the FINAL CY 2026 per-visit payment rates for those HHAs that submit the required quality data, for LUPA periods that occur as the only period or an initial period in a sequence of adjacent periods, if the first skilled visit is SN, the payment for that visit would be $304.37 (1.7200 multiplied by $176.96), subject to area wage adjustment.

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Payment Pricing

Claim payments subject to pricing

- OASIS Validation is the first step – the Claim will RTP if the OASIS data and the claim do not match.
- Payment period timing
  - Claim payments to be automatically repriced for early or late status based on paid claims history on Medicare CWF (Start of Care ONLY)

Admission source

- **Occurrence codes 61 & 62** will now be used to trigger payment calculation for Institutional vs. Community. Claims data will be utilized to reconcile periodically with the Institutional credit given.

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Payment Pricing

Clinical Grouping & Comorbidities

- The primary & all secondary diagnoses are taken from the CLAIM to determine the Clinical Grouping and Comorbidity level.

Functional Scores

- OASIS Responses will be extracted from the OASIS-D1 and used to calculate the HIPPS code
- The final HIPPS code calculated by the Medicare MAC is the one that your final claim payment will be based on regardless of the HIPPS code that you sent in on the claim.

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NOA 2026 - EXAMPLE

Start of Care 60-DAY Episode with 30-day PAYMENT PERIODS
01/03/26 – 02/01/26 & 02/02/26 – 03/04/26

NOA filed and accepted at MAC on 02/20/26

- HIPPS Code value $2,800 for 1st Period and $1,800 for 2nd Period

When 1st final is paid the agency will receive the following payment:

- $0 due to NOA be accepted after the first 30-day period is over.

When 2nd final is paid the agency will receive the following payment:

- $1,800 divided by 30 = $60 per day
- $60 X 18 days (2/2 – 2/19) = $1,080
- $1,800 - $1,080 = $720

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Requesting an Exception for NOA

An HHA may request an exception if the NOA is filed more than 5 calendar days after the period of care. The four circumstances that may qualify for an exception are:

- Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate.
- An event that produces a data filing problem due to a CMS or MAC system issue that is beyond the control of the HHA.
- A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from MAC.
- Other circumstances determined by CMS or MAC to be beyond the control of the HHA.

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Requesting an Exception for Late NOA

To request an exception, enter information supporting the circumstance (listed above) that applies to the NOA in the REMARKS field on the Claim (FISS Claim page 04). For example, if the NOA to a claim was originally received timely but the NOA was canceled and resubmitted to correct an error, enter in the REMARKS field "Timely NOA, cancel and rebill". Add modifier KX to the HIPPS Code reported on the revenue code 0023 line of the Final Claim.

If the information provided in the REMARKS field is not clear, MAC will request documentation by generating a non-medical review additional development request (non-MR ADR). HHAs will need to submit documentation supporting the exception request. When a non-MR ADR is generated, the claim will be moved to status/location S B6001.

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OUTLIER

Using CY 2024 claims data, we found that the FDL ratio would need to be increased from the final CY 2025 FDL of 0.35 to 0.37.

With updated CY 2024 claims data (as of July 11, 2025) and given the statutory requirement that total outlier payments not exceed 2.5 percent of the total payments estimated to be made under the HH PPS, we are finalizing an FDL ratio of 0.37 for CY 2026.

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Face-to-Face Requirements Not Met

5FF2F/5TF2F — Face-to-Face Encounter Requirements Not Met

- **Reason for Denial**
  The services billed were not covered because the documentation submitted for review did not include (adequate) documentation of a face-to-face encounter.
- **How to Avoid This Denial**
  Specific documentation related to face-to-face encounter requirements must be submitted for review. This includes, but is not limited to, the following:
  - A face-to-face encounter must occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
  - Encounter was related to the primary reason the patient requires home health services; and
  - Encounter was performed by a physician or allowed nonphysician practitioner
- **The certifying physician must also document the date of the face-to-face encounter.**

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Face-to-Face Encounter FINAL Update

Finalize to revise § 424.22(a)(1)(v)(A) to state that the face-to-face encounter must be performed by one of the following: a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant as defined at 42 CFR 484.2; or a certified nurse-midwife as defined in section 1861(gg)) of the Act as authorized by State law. We also finalize to remove § 424.22(a)(1)(v)(C), which limits the face-to-face encounter to the certifying physician or allowed practitioner unless the encounter is performed by either of the following:

- A certified nurse midwife as described in paragraph (a)(1)(v)(A)(4) of this section.
- A physician, physician assistant, nurse practitioner, or clinical nurse specialist with privileges who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.

The additional flexibility should decrease ambiguity regarding which providers are able to complete the face-to-face encounter and potentially improve access to home health services by increasing the number of providers allowed to perform the face-to-face encounter.

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Face-to-Face Requirements Not Met

- **The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:**
  1. Occurred within the required time frame;
  2. Was related to the primary reason the patient requires home health services; and
  3. Was performed by an allowed provider type
- **This information can be found most often in, but is not limited to the following examples:**
  - Discharge summary;
  - Progress note;
  - Progress note and problem list; or
  - Discharge summary and comprehensive assessment

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TELEHEALTH Face-to-Face

- Telehealth visits allowed to meet the **Face-to-Face (F2F)** requirement for all patients
- This visit would be conducted by allowed physician or NP (PA not allowed)
- These visits are NOT reported on the claim.
- F2F via telehealth is extended through **December 31, 2027** after which CMS expects telehealth services to be summarily limited to follow-up contact with patients and would not expect to see provision of hospice services furnished via telecommunications systems
- Telehealth system utilized must be HIPAA Compliant

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Thank You!

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